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Trial Marriage: Florida's Experience in Consolidating HIV/AIDS, STD, and TB Programs

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SYNOPSIS

After a three-year experiment in consolidating services, the Florida Department of Health has again separated programs for the prevention and control of HIV/AIDS, sexually transmitted diseases (STDs), and tuberculosis. The authors report that while there were some clear advantages to consolidating services, especially programs dealing with HIV and other STDs, the individual programs suffered in some important ways. The authors describe Florida's effort to preserve the positive programmatic and administrative aspects of the consolidated approach and to apply the lessons learned.

Many states have combined or are considering combining prevention and care services for sexually transmitted diseases (STDs) and HIV/AIDS. Such decisions are important, difficult, and have potentially long-lasting effects. After a three-year experiment in consolidation, the Florida Department of Health has recently separated its programs for the prevention and control of HIV/AIDS, STDs, and tuberculosis (TB). This article describes Florida's experience and gives an overview of the advantages and disadvantages of each approach. It should be instructive to those who are contemplating a similar restructuring.

A bit of history will set the context.

The Florida Department of Health and Rehabilitative Services (HRS) was created in 1969 as part of a broad reorganization of state government. HRS swept together about three dozen units of government that dealt, in broad terms, with human services. HRS had nine divisions, one of which

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was the Division of Health. Despite the reorganization, the prevailing opinion in the state legislature in the next half dozen years was that many of the units in HRS were functioning just as they had before, that there was virtually no cooperation among them, and that many of the Department's clients were falling through the cracks.

In 1975, the legislature sought to remedy this by forcing the elimination of individual units within HRS, with the goal of establishing an integrated, yet decentralized, department. Division of Health functions were reallocated and redistributed. Public health units—responsible for the delivery of all public health services, from environmental health inspections to control of disease outbreaks—were established in each of Florida's 67 counties. Eleven districts were formed to facilitate the administration of both public health and social services. The HRS headquarters staff in Tallahassee were considered planners and policy makers; the districts had administrative and management authority over the 67 county health units, with county public health officials reporting to district supervisors. Nevertheless, the effective delivery of public health continued to be an issue in the legislature. Rising costs put health care out of the reach of an increasing number of the state's citizens, and because of a series of widely publicized mistakes and some acknowledged instances of misuse of funds, HRS came to be equated in the public mind with bureaucratic inefficiency and mismanagement.

In 1993, lawmakers responded with another reorganization. The legislature increased the number of districts to 15 in an effort to make them more responsive to local needs; in one case, a single county (Palm Beach County) became a district onto itself. The legislature also created a health and human services board for each district with the idea of increasing the level of community involvement in shaping HRS policy, and the boards in fact wielded considerable power in both the public health and social services arenas. However, the legislature did not increase the HRS budget to accommodate the increased number of district-level positions to be filled. This created an impetus to combine programs and staff to free up money to pay for the newly mandated positions.

Once the state legislature acted, the Acting Secretary of HRS reacted. The state HIV/AIDS, STD, and TB programs—dealing with interrelated diseases—seemed to be strong candidates for consolidation. The Chiefs of the three programs were ordered to unite under one roof—in less than six weeks—scores of people and their files, equipment, and furniture previously housed in separate buildings in various parts of Tallahassee. Senior public health workers, some with decades of experience, were shifted abruptly to new positions and given new responsibilities. And the three Chief positions disappeared almost overnight, replaced by one Chief of a combined program that did not even have a name yet. In short, the way in which consolidation of services was effectuated in 1993 was less than ideal.

THE HIV/STD/TB PROGRAM

The new, consolidated program was housed in one building in Tallahassee, offering support to all district and county public health units. Its administration provided guidance and technical assistance in program and fiscal planning, coordination of program responsibilities, and other cross-cutting areas. The staff was organized into six units that the program's Chief and Associate Chief and the Health Officer for Disease Control felt addressed issues and needs of the three disease areas in a manner appropriate to the new, consolidated approach.

The Program Policy and Resource Development Unit dealt with legal, legislative, and personnel issues, coordinated policies and special projects, and identified and evaluated health status outcome indicators. Program Planning and Management developed prevention and education initiatives, including HIV counseling and testing protocols and cross-training modules, and provided technical assistance to health professionals and organizations. Program Support and Technical Assistance provided technical support and expertise to county public health units, HRS district offices, community-based organizations, universities, and other providers concerning the practical application of disease control strategies; coordinated surveillance and reporting activities; and prepared grant proposals and quarterly reports. Patient Care Resources was responsible for HIV patient care services funded through Federal grants and state general revenue. In the Medical Unit, two physicians—specialists in HIV/AIDS and TB, respectively—and two nurse consultants provided technical assistance in HIV/AIDS, STDs, and TB. Program Reporting collected and analyzed data from all three disease areas.

This was the shape of the HIV/STD/TB Program—later renamed the Office of Disease Intervention (and still later, in 1996, renamed the Bureau of Disease Intervention). How well did it work?

Advantages and disadvantages of consolidation. No analysis was ever done to determine whether the reorganization of 1993 in general, and the consolidation of

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these three programs in particular, was ultimately cost-effective. Programmatically, it soon became clear that there were both advantages and disadvantages. First, the advantages:

Easier development of data systems. The consolidated program made it easier to share technical expertise for the design and development of data management systems and to integrate systems at the service delivery level.

Enhanced communication. The key here was the formation of a management team that consisted of the Chief of the combined operation and the chiefs and key managers in the program areas—about a dozen people in all. The team met weekly.

Flexibility in use of staff. From the outset, the program administration in Tallahassee made a strong effort to provide comprehensive, continuing orientation of staff to make them aware of the program as a whole and of its mission. Cross-training gave managers opportunities to deploy resources in new ways that benefited the program and, of course, its clients, the people of Florida.

However, it soon became clear to almost everyone in the new program that there were also significant disadvantages to the consolidated approach. Some of these were programmatic in nature and some the result of the haste with which three major public health programs had been joined together. The problems ranged from matters that seemed (but often were not) inconsequential to issues that went to the heart of public health. Among the programmatic issues:

Smaller programs dwarfed. Virtually any public health program that has to share administration and staff with an AIDS program is going to operate at something of a disadvantage. Dollar figures tell part of the tale: in 1994, Florida's HIV/AIDS programs had a budget of about $65 million, while the STD budget was about $4 million and the TB budget about $13 million. This translated, of course, into very different staffing and office space needs. Furthermore, under consolidated services, only the Chief of the Office of HIV/STD/TB was allowed to participate in the higher-level department meetings at which policy was initiated; he was an AIDS administrator whose knowledge of the three program areas was not uniform. Finally, the problems of continuing STD prevention and control and of trying to contain a resurgence of TB simply did not catch the attention of the public health and scientific communities, the general public, or the state legislature the way the HIV/AIDS epidemic did, so that if there were pressing issues in all three areas on a given day, STDs and TB staff often had to shift for themselves while the AIDS situation was resolved.

Lack of control over budget functions. Before the consolidation, each of the three programs had its own budget analyst, but those positions were moved into a department-level budget office. This was a legitimate effort to economize, but the new system put another layer of bureaucracy between managers and administrators who were involved in—and responsible for—the day-to-day operation of the programs and those who considered and ultimately approved budget requests. The result was more time spent on trying to articulate program priorities and budget needs to people largely unfamiliar with the realities of specific areas of disease prevention and control.

Lack of direction for districts. As headquarters struggled with these and other issues, the districts were mostly left to pattern themselves after what they perceived was happening in Tallahassee. Perceptions varied widely, and the result was a lack of consistency and a somewhat spotty performance. This was particularly true in TB control

(see below) and in STDs, where the steady progress that had been made toward meeting objectives and expanding initiatives—screening for chlamydia, for example—was slowed. Had this abrupt consolidation occurred during a time of rising STD morbidity, there might have been a public health disaster because this was a period in which the headquarters staff were giving very little support to the field staff—a principal function of leadership.

Other disadvantages were the result of various combinations of inadequate planning, poor staffing decisions (or no staffing decisions), and, to some extent, bad luck. Among them:

Misplaced functions. Inevitably, the six program units might have been more effective had more time been spent before consolidation in reflecting on their composition, their relationship to each other, and the tasks that awaited. In fact, it became evident early on that some of the right pieces had been put in the wrong places—that HIV counseling and testing, for example, should have been placed with STDs. In another area, it turned out to be a major problem that the Program Reporting Unit, while effective and productive, lost its day-to-day relationship with the formerly separate programs; data are the lifeblood of those programs, and for them to be dissociated in this way was very damaging.

Failure to integrate medical services. Two full-time physicians, one for TB and one for AIDS, and two nurse consultants (TB and STDs) were on staff at the time of the consolidation. The AIDS physician became medical consultant to the new consolidated program but left within a year. The TB physician, a dedicated clinician, left the program soon after that. The result was that the Medical Services Unit foundered early and was disbanded within a year, and the consolidated program limped along for some time without the medical expertise that would have been appropriate for the fourth most populous state in the nation.

Disruption of the TB control program. This was a case of poor planning compounded by bad luck. The TB program lost substantial funding and a large number of positions, including the Chief's position, in the consolidation. Programmatic leadership was provided on an interim basis by a public health veteran who had decades of field and administrative experience—in STDs—and a new TB program manager did not arrive for almost two years. The effects were felt most acutely in the field. At precisely the moment when the TB incidence curve had stopped its downward progression and TB control efforts were being challenged by a range of HIV-related issues and the emergence of more multidrug-resistant strains of TB, no experienced leader was available to help the county health units manage a TB program. Thus, in a crucial period for TB control, Florida's TB program lost ground in such key areas as training and current science.

Layoff problems. Because of the "downsizing" of the department overall, a number of people were "bumped" (reassigned according to seniority) into the Office of HIV/STD/TB and were placed in jobs for which they were not prepared. This led to personnel problems and a general decline in morale.

In short, consolidation of Florida's HIV/AIDS, STD, and TB programs in 1993 brought with it some clear advantages and some real problems. How did these play out across this varied state?

Where consolidation of services worked: Florida's Central Panhandle region. District 2 encompassed 14 counties of the Central Panhandle region of north Florida. Its two main urban centers are Tallahassee/Leon County, with more than 200,000 people, and Panama City/Bay County, population about 133,000. In this mostly rural area, consolidation of the HIV/AIDS, STD, and TB programs had begun in mid-1992, more than a year before the administrative directive was issued from Tallahassee.

Thus, when the current District 2 STD program manager took over in 1993, cross-training and consolidation of services were already on the verge of being implemented and the district managed to avoid many of the problems that the rapid transition caused elsewhere in the state. Three types of training had to occur: HIV/AIDS and STD staff had to learn about TB; TB program staff had to learn HIV/AIDS and STDs; and new employees had to learn all three areas instead of just one. (HIV/AIDS-STD cross-training had in effect already occurred in District 2 because STD staff there already had begun providing HIV counseling and testing and partner notification services.)

"Cross-training has yielded positive outcomes for us in this area," the program manager said in an interview in 1997. "Three of our disease intervention specialist (DIS) positions are TB-funded, and the rest are HIV-STD. One DIS currently has 17 TB patients who require directly observed therapy, another has one, another four, another

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seven—and they all do all other things, too. Consolidation of services took about six months. A lot of HIV and STD people had trouble with the medical aspects of TB, but as far as follow-up, TB was easier than STD and HIV because TB patients usually appreciate you more and there often is a special rapport between patient and staff."

"We learned a lot from this whole process," the program manager said. "We learned that in a situation such as ours, everyone can consolidate services—if you are talking to an HIV client, for example, you begin offering TB services and check for other STDs. We became more aware of the relationship between HIV and TB. We have been able to screen the high risk community for all three infections at one time—the homeless, jail inmates, clients at drug rehabilitation centers, and people at health fairs, which are very much a part of the rural community health scene."

The nine DISs are based in Tallahassee-Leon County, Panama City-Bay County, and Quincy-Gadsden County. (The latter is one of the poorest regions in the state and historically has among the highest syphilis and gonorrhea rates in the nation.) The DIS's workload now typically consists of very little syphilis, some HIV, TB contact investigations, and selected partner notification for chlamydia and gonorrhea. Each DIS is responsible for liaison activity with outside organizations such as jails and shelters and popular meeting places such as hair salons, which they visit with educational materials. The team has established an effective jail and prison screening and education program. "We screen everyone who comes into the county jail and is there for between three and seven days," the program manager said. "We do this in most counties, except in a few where there has been resistance from the local sheriff. This results in 400 to 500 tests per month in the region, with Leon County [Tallahassee] accounting for somewhat more than half of the total." The health director of the region's most populous county looks to the program manager to fill the leadership role in all three areas, and here as in the rest of the region she is overall manager for the HIV and STD programs and field manager for the TB staff.

In sum, there were three reasons why consolidation of services was successful in District 2:

- The process had begun prior to and independent of the formal mandate in 1993 and thus avoided the organizational trauma associated with the rapid consolidation of services in other geographic areas.
- The relatively low population density of the area made disease prevention and control more manageable because the sheer numbers of clients were smaller and access to them was more clearly defined than in, for example, the major population centers of South and Central Florida. Although there were about twice as many DISs in Dade County as in District 2, each Dade worker's case load was much larger. (Today, for example, there are about 40 new cases of HIV infection reported in Dade County each month, compared with about 10 new cases in the Central Panhandle region.)
- The program manager in District 2 happened to be ideally suited, professionally and temperamentally, to effect the consolidation of services in an orderly, efficient way—the right person in the right place at the right time.

There were, to be sure, some difficulties associated with consolidation in District 2. The staff struggled with certain issues, such as time management; with TB directly observed therapy, for example, it can sometimes take all day to find one patient. Also, there was some resistance to consolidation of services, particularly from STD and TB staff. Flex time was helpful in getting the job done in a way that was acceptable to the staff, the program manager says, and employee surveys showed a high level of satisfaction.

Where consolidation of services didn't work: Dade County. In Dade County (Miami), the local health

department responded with enthusiasm to the directive to consolidate services. (Dade was one of two counties in District 11; the other was Monroe County, which includes Key West; both have AIDS case rates that are among the highest in the nation.) The district administrator, whose career experience was more in law than public health, was a vocal and articulate proponent of consolidation and of the "one-stop shopping" approach to delivering public health (and other) services. The result was the creation of an entity within the county health department called Disease Prevention and Care Services, which incorporated all aspects of the district's AIDS, STD, and TB programs.

"The concept was excellent," the acting manager of HIV, STD, and TB services for the Dade County Health Department said in an interview in 1997. "We had been constantly going to the same houses, different people going for different reasons."

But there were real difficulties, too. Not only did Dade County not have a head start on consolidation of services, it was probably the jurisdiction in the state that would have benefited most from a well planned, orderly transition. The acting manager pointed out that in an urban area—or at least, in this urban area—the cards were stacked against consolidation of services because of the huge numbers of clients and the extensive and specialized training needed to provide truly consolidated services.

"The training people received in areas not their own was ultimately superficial," the manager said. "There was no real focus on what the problems or objectives were, and it was difficult and unrealistic to get someone in TB trained in STDs, for example, and then to expect that person to train his or her staff in STDs. It takes a different kind of person to be a DIS than it does to do TB contact work; the two kinds of work yield different kinds of satisfaction." TB workers found it difficult to elicit the names of sex partners from STD patients, for example, although DISs generally had no trouble with TB contact work.

Superficial training had a negative effect on staff morale and ultimately led to incidents that were symptoms of a system that was not working well. In September 1996, for example, a high school student became infected with TB because the directly observed therapy of a contact was not carried out properly. This led to a "political screening" in the school, a low-yield exercise carried out less as a public health measure than to satisfy those who had been alarmed and angered by the much-publicized isolated case. The consensus at headquarters in Tallahassee was that the case occurred because the TB staff, although in place before consolidation of services, were not doing their job properly because their supervisor was an STD person and was promoting STD control activities at the expense of other areas of concern.

Programmatically, it was difficult to manage the structured TB work load alongside the STD program, which depends on finding someone when you can and taking the time to talk with him or her on the spot. What do you do when you have one patient—a pregnant woman with a high titer, for example—whom you have to get in to the clinic and another, across town, who is supposed to have some medications at a specific time? The sheer size of the case loads in Dade County, plus the difficulty of finding clients—often homeless people—in a densely populated setting, made it hard for the staff to fix priorities and hard for the managers to keep track of who was doing what.

Finally, it must be said that Dade County is home to diverse subpopulations with different cultural traditions and morbidity patterns, all presenting different public health challenges. The AIDS/STD/TB staff is also ethnically diverse—but in very different proportions from the population. There are tensions among ethnic groups, both within the program staff and between staff and clients, that would complicate the delivery of disease prevention and control services even under the best circumstances.

THE IMPETUS TO RETURN TO SEPARATE PROGRAMS

When the experiment with consolidated HIV/AIDS, STD, and TB programs was three years old, the prevailing view in the Bureau of Disease Intervention at HRS headquarters in Tallahassee was that the shortcomings of this approach outweighed the benefits. It was the consensus of the Bureau's administration that the three programs would be better off on their own.

In 1996, opportunity knocked. Bills to separate HRS into separate departments for health and social services had been introduced in the state legislature annually starting in 1990. Their authors were influenced by public health officials who felt that public health priorities in Florida would be better served by a separate department than they could be while they remained joined to a huge social services apparatus; it would also be desirable to have a leader whose experience and expertise was in public health and not in social services. Such a bill finally passed during the 1996 legislative session. (In Florida, the legislature meets from March to May.) Under the bill's provisions, the Florida Department of

Health and Rehabilitative Services would cease to exist on January 1, 1997, and would be replaced by the Department of Children and Families and the Department of Health (DOH). The 15 public health districts would disappear; in the new organizational structure, the 67 county health departments would report directly to the DOH in Tallahassee.

In the midst of preparing for the transition from HRS to DOH, it became clear to the administration of the Bureau of Disease Intervention that this was a key political moment—the perfect time to separate AIDS, STD, and TB programs. The Associate Chief of the Bureau, who had administrative responsibility for the STD and TB programs, the Associate Chief of the HIV/AIDS program, and the Division Director for Disease Control took a proposal for three bureaus instead of one to the Secretary of the new Department of Health, who approved it.

It was a period of momentous change for public health in Florida in general, and for the HIV/AIDS, STD, and TB programs in particular. Still, even in the midst of the frenetic activity associated with these changes (and with carrying on the daily business of three aggressive disease control programs), administrators found time, this time around, to reflect on how to retain the best of both approaches and avoid repeating the poor management and staffing decisions of 1993 that had encouraged failure in some program areas.

They were determined to preserve certain features of the consolidated program that worked well, including:

Field manager/coordinator meetings. These statewide sessions for HIV/AIDS, STD, and TB managers are held quarterly.

Integrated technology. The data collection and communications systems that were developed at headquarters and in the field remain intact. Its administrators provide support and technical assistance to the field and report to the director of disease control.

Program report. A publication titled *Intervention Update* has appeared every two months since November 1995 and continues to be a means of linking the three now-separate programs. Monthly surveillance reports that cover all three program areas and a combined annual report are also being continued.

Quality Improvement (QI). The QI process continues to be a joint effort in which staff representing all three programs will work together in QI visits to the counties.

Grant proposals. Planning and development of Federal grant proposals that affect all programs are shared, and the documents are reviewed and approved by all before submission to the grantmaking agencies.

Strategic planning. Legislative budget requests (LBRs) and other funding and development projects continue to involve all three bureaus, and some issues that cross program lines may be rolled up into one LBR.

LESSONS LEARNED

Several general lessons can be drawn from Florida's experiment with consolidation of HIV/AIDS, STD, and TB services.

Beware diffusion of expertise. Experts in specific areas came to feel that their impact and effectiveness was diminished during the three-plus years of consolidated HIV/AIDS, STD, and TB services in Florida, and the impression extended from Department of Health headquarters in Tallahassee to countless workers at the local level. When a program loses its will or ability to provide the highest level of specialized advice and support, it loses one of its major reasons for existence.

The 500-pound gorilla. Second, a lesson specific to the late '90s: when programs of this sort are consolidated, the HIV/AIDS program will tend to dwarf the others. Every program has a need to seek a certain level of visibility and to engage in a certain amount of self-promotion; this serves to advance the goals of public health (and to secure additional funding from public and private sources). The funding needs of the AIDS epidemic are so substantial, however, and its political profile so high that any attempt to focus on something else—the need for routine screening for chlamydia, for example—simply tends to get lost in a combined program.

Avoid radical change. Finally, change is good, but beware radical organizational change imposed on a public health structure in haste and largely to serve political ends. The public health community has proved time and again, in Florida and elsewhere, that it can continue to design and deliver effective program under these circumstances, but they certainly complicate life and there are bound to be casualties—the short-lived Medical Unit is an example. Bargain for as much time and flexibility as possible. ■